IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

September 12, 2006

FILE COPY

Susan Broetje, Administrator
Idaho State School and Hospital
3100 Eleventh Avenue North
Nampa, ID 83686

Re: Non-Renewal of ICF/MR Provider Agreement Idaho State School and Hospital, Provider #13G001

Dear Ms. Broetje:

On August 28, 2006, a follow-up survey of Idaho State School and Hospital, found that the following Conditions of Participation remained not met from the May 22, 2006 survey and the June 19, 2006 survey of the facility: Governing Body and Management (42 CFR §483.410), Client Protections (42 CFR §483.420) and Client Behavior & Facility Practices (42 CFR §483.450). This determination was shared with you and Idaho State School and Hospital staff on August 28, 2006.

Since compliance has not been achieved, the Bureau of Facility Standards is unable to recommend recertification to the Bureau of Behavioral Health. As a result, Idaho State School and Hospital's agreement to participate in the Medicaid program will not be renewed.

You have the right to appeal this action as described in 42 CFR §431.151 through 431.154. Under the Department's contested case procedures (IDAPA 16.05.03.300), the facility has until **October 10, 2006**, in which to file an appeal.

Your written request should be sent to the following address:

Randy May, Deputy Administrator
Division of Medicaid
Idaho Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0036
Fax: 208-364-1811

If a petition for appeal is received on or prior to October 10, 2006, the facility's payment for all Medicaid clients may continue until December 31, 2006, (120 days after expiration of the provider agreement which expired on August 31, 2006) or until a decision is issued by a hearing officer, whichever is earlier in time, as stated in 42 CFR §442.40(d)(2)(ii).

During the appeal process the facility may submit a credible allegation of compliance and invite a survey team to conduct a follow-up survey. Should the facility be found in compliance with all Conditions of Participation, the Department will renew the facility's agreement to participate in the Medicaid program.

If you have any questions, please contact Sylvia Creswell at 208-334-6626.

Sincerely,

DEBRA RANSOM, R.N., R.H.I.T., Chief
Bureau of Facility Standards

PAUL LEARY
Acting Deputy Administrator

DR/mlw
Enclosure

ec: Catherine Mitchell, CMS Regional Office
Willard Abbott, Deputy Attorney General, DHW
Sylvia Creswell, Supervisor, NLTC
Randy May, Deputy Administrator, Division of Medicaid
Michelle Britton, Administrator, Division of Family & Community Services
Judy Ripke, MH/DD Manager Region 4, DHW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	R 08/28/2006

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IDAHO STATE SCHOOL AND HOSPITAL	3100 ELEVENTH AVE NORTH NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your follow up survey. The surveyors conducting your survey were: Sherri Case, LSW, QMRP, Team Leader Michael Case, LSW, QMRP Lois Hollingsworth, R.N. Nicole Wisenor, QMRP Monica Williams, QMRP Common abbreviations/words used in this report are: ABC - Antecedent, Behavior, Consequence AD - Administrative Director AOD - Administrator on Duty BM - Bowel Movement BRC - Behavior Review Committee BRF - Behavior Reporting Form BSP - Behavior Support Plan DCS - Direct Care Staff DOP - Destruction of Property HIS - Human Interaction System HRC - Human Rights Committee IDT - Interdisciplinary Team IM - Intramuscular HRC - Human Rights Committee LPN - Licensed Practical Nurse LWOP - Leave Without Permission MRSA - methicillin resistant Staphylococcus aureus is used to describe those examples of this organism that are resistant to commonly used antibiotics. OPFR - Nursing Notes PCP - Person Centered Plan PICA - Ingesting non-edible material PO - By Mouth PRN - As Needed QMRP - Qualified Mental Retardation	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 Professional RN - Registered Nurse SIB - Self-Injurious Behavior SER - Significant Event Report	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on record review and staff interviews, it was determined the facility's governing body failed to take actions that identified and resolved systematic problems of a serious and recurrent nature. As a result, individuals' health, safety, and behavioral services were negatively impacted. The findings include: 1. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies. The facility was cited at W104 during an annual recertification survey dated 3/8/02, a complaint investigation dated 4/24/03, a recertification survey dated 8/1/03, a follow up survey dated 5/5/04, a recertification survey dated 3/29/05, and a recertification survey dated 6/19/06. 2. Refer to W122 - Condition of Participation: Client Protections and related standard level deficiencies including W127 as it relates to the facility's failure to ensure individuals were not	W 102		

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W 102	Continued From page 2 subjected to neglect or mistreatment. The facility was cited at W122 during an annual recertification survey dated 3/8/02, a follow up survey dated 6/28/02, a complaint investigation dated 4/24/03, a recertification survey dated 8/1/03, and a recertification survey dated 6/19/06. 3. Refer to W266 - Condition of Participation: Client Behavior and Facility Practice as it relates to the facility's failure to ensure individual programs were sufficiently developed, implemented, and monitored to meet individuals' behavioral needs. The facility was cited at W266 during an annual recertification survey dated 3/8/02, a follow up survey dated 6/28/02, a recertification survey dated 8/1/03, and a recertification survey dated 6/19/06.	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility's governing body failed to take actions that identified and resolved systematic problems for the individuals residing at the facility. This failure had the potential to negatively impact 96 of 96 individuals (Individuals #1 - #96) residing at the facility. Failure of the governing body to ensure these requirements were met resulted in the facility being found out of compliance with three (3) Conditions of Participation, and an individual being placed in	W 104		

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W 104	Continued From page 3 serious and immediate jeopardy. The findings include: 1. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the facility's failure to ensure individuals were not subjected to abuse, neglect, and/or mistreatment. The facility was cited at W127 during an annual recertification survey dated 3/8/02, a follow up survey dated 6/28/02, and a recertification survey dated 6/19/06. 2. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure individuals' services were sufficiently monitored and coordinated by the QMRP. The facility was cited at W159 during a complaint investigation dated 4/24/03, a recertification survey dated 8/1/03, a follow up survey dated 5/5/04, a follow up survey dated 8/26/04, a recertification survey dated 8/27/04, a recertification survey dated 3/29/05, and a recertification survey dated 6/19/06. 3. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to providing behavioral services to individuals. The facility was cited at W214 during recertification surveys dated 3/29/05 and 6/19/06. 4. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to ensuring program implementation plans included sufficient direction to staff. The facility	W 104		

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W 104	Continued From page 4 was cited at W234 during an annual recertification survey on 8/1/03, the follow up surveys dated 5/5/04 and 8/26/04, a recertification survey dated 3/29/05, and a recertification survey dated 6/19/06. 5. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure the human rights committee was provided with sufficient review information prior to obtaining approval for restrictive techniques. The facility was cited at W262 during the annual recertification surveys dated 3/8/02 and 6/19/06. 6. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure the use of physical restraints, as a behavioral intervention, were written into individuals' PCPs. The facility was cited at W295 during the annual recertification surveys dated 3/8/02 and 6/19/06. 7. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to plans to reduce the use of behavior modifying drugs. The facility was cited at W312 during the annual recertification surveys dated 3/8/02, 3/29/05, and 6/19/06.	W 104		

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W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on review of incident/accident reports, record review, and staff interviews it was determined the facility failed to provide the necessary client protections and ensure steps were taken to protect individuals. This resulted in an individual not being provided sufficient staff supervision necessary to ensure her health and safety, an individual receiving unnecessary chemical restraints, and individuals' privacy and freedom of movement were restricted without appropriate consents and programming in place. The findings include: 1. Refer to W127 as it relates to the facility's failure to ensure individuals were provided with sufficient staff supervision necessary to ensure their health and safety. 2. Refer to W128 as it relates to the facility's failure to ensure individuals were free from unnecessary chemical restraints. 3. Refer to W133 as it relates to the facility's failure to ensure an individual's right to freedom of movement was not restricted without appropriate consents and programming. 4. Refer to W262 as it relates the the facility's failure to ensure restrictive interventions were implemented only with the approval of the human rights committee.	W 122		

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W 122	Continued From page 6 5. Refer to W263 as it relates to the facility's failure to ensure restrictive interventions were implemented only with the written informed consent of the individuals' guardians.	W 122		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on review of incident/accident reports, record review, and staff interviews it was determined the facility failed to provide sufficient supervision, monitoring, and intervention necessary to ensure the health, welfare, and safety of individuals. This failure directly impacted 1 of 7 individuals (Individual #1) whose SERs and Behavior Support Plans were reviewed. The lack of sufficient staff supervision and intervention placed an individual in serious and immediate jeopardy. The findings include: 1. Individual #1's PCP, dated 6/20/06, documented an 18 year old female diagnosed with mild mental retardation, schizoaffective disorder bipolar type, oppositional defiance disorder by history, borderline personality disorder, gastroesophageal reflux disease (refers to the clinical manifestations of reflux of stomach contents into the esophagus), and gallstones. She was admitted to the facility on 5/22/06.	W 127		

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W 127	Continued From page 7 Her Comprehensive Psychiatric Evaluation, dated 6/2/06, documented she had "a long history of self-destructive, self-injurious behavior, assaultive behavior, and generally problematic behaviors." The Evaluation stated she was transferred to the facility from a psychiatric hospital. She was admitted to the psychiatric hospital because of intentional medication overdoses and cutting herself. The Evaluation stated she had a number of hospitalizations and had been institutionalized "for a long time." The Evaluation stated "She has a tendency to cut herself and also has had a history of pica, including eating zippers, glass, plastic utensils, and broken CDs, associated with symptoms of anxiety. She denied being assaultive to others but will be verbally assaultive and, by reports, has been physically assaultive also and has also set fires and destroyed property...She noted that she gets depressed a lot and anxious all the time. She would not elaborate on questions about hallucinations...she has certainly complained of auditory and visual hallucinations in the past." The Evaluation stated the plan was to increase Naltrexone (adjunct for maintenance of opioid free state in detoxified persons) to 100 mg a day for the purpose of decreasing her self-injurious behavior, continue Seroquel (an antipsychotic) 200 mg a day to control her mood swings and psychotic behavior, and continue Prozac (an antidepressant) 20 mg a day for her depressive symptoms. Her Psychological Report, dated 6/9/06, documented she was admitted to the facility for "behaviors that were dangerous to herself (e.g., self injury (primarily cutting), eloping, suicidal ideation, suicide attempts) and to others (e.g., physical assault, verbal assault, spitting, blood	W 127		

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W 127	Continued From page 8 throwing, firesetting, destruction of property)... [Individual #1] has complained of visual and auditory hallucinations, sometimes related to the devil. She has complained of nightmares and she sometimes fixates on dead babies or other things that she says are scary. Records suggest that [Individual #1] may have trouble with being touched." Individual #1's BSP, dated 6/23/06 and revised 7/25/06, included the following target behaviors and their definitions: - SIB was defined as cutting on herself, banging her head, and scratching her body. - Physical Assaults was defined as spitting, smearing body fluids onto another person, hitting, kicking, or throwing objects at others. - Psychotic behavior was defined as hallucinations and delusions. Hallucinations were defined as seeing or hearing things that other people did not see or hear. Delusions were defined as talking about things that were bizarre, unreal, things that really did not occur, or suspiciousness related to an issue that was not happening. - Suicide Ideation was defined as any verbal or written comment or statement made indicating Individual #1 wished to kill herself. If Individual #1 was making suicide statements and engaging in SIB and PICA at the same time, it was to be reported as a suicide attempt. - PICA was defined as eating or drinking something that was not edible. The facility's Enhanced Supervision policy, revised 6/5/06, defined arm's length supervision as "An assigned staff person maintains supervision at a distance no greater than three (3)	W 127		

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W 127	Continued From page 9 feet and is able to intervene immediately as needed." Close Proximity supervision was defined as "An assigned staff person maintains supervision at a distance of no greater than approximately twenty (20) feet and is able to intervene within ten (10) seconds." When asked if close proximity included visual supervision at all times, the Clinician stated during an interview on 8/24/06 from 9:30 - 11:05 a.m., yes. When asked about visual supervision in the bathroom, they stated staff were to be visually watching Individual #1 at all times. Individual #1's records documented she repeatedly injured herself due to a lack of sufficient program structure and staff supervision as follows: The facility's Significant Event Reports (SER) and Individual #1's OPFR Charting notes, dated 6/2/06 - 8/21/06, documented the following: - An Initial Request for Enhanced Supervision, dated 6/2/06, stated Individual #1 had been picking at an old wound and reopened it two times. The Request stated staff had been monitoring her closely but she was not staffed one-to-one. The Request was for Individual #1 to be put on close proximity (defined as "An assigned staff person maintains supervision at a distance of no greater than approximately twenty (20) feet and is able to intervene within ten (10) seconds"). - An Initial Request for Enhanced Supervision, dated 6/3/06, stated close proximity did not work as Individual #1 swallowed medication for another	W 127		

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W 127	Continued From page 10 individual and wounded herself in the arm three times in less than 24 hours. The Request was for Individual #1 to be put on arms-length supervision. - 6/14/06 at 1300: An OPFR Charting note stated "[Individual #1] presented to nurse's station accompanied by staff after cutting her bilateral forearms...She states she got a piece of broken glass while working at the park earlier in the day... [doctor] present at time she presented to nurse's station and immediately assessed...noted right forearm - 3 lacerations to #1 (distal aspect) - 2 cm long - #2 - 1 cm - #3 - 1 ½ cm (proximal). Noted multiple superficial cuts and abraded skin extending from mid forearm to antecubital area. Left forearm - laceration 2 cm long at least 17 superficial horizontal cuts and abraded areas. [Individual #1] stated she felt [sic] 'better' after she cuts herself. She stated she did it in her bathroom and then after went out and notified staff...anxious in med (medical) bldg (building) exam room while lacerations sutured...[QMRP] initiated Emergency team mtg (meeting)...Immediately placed on arm's length enhanced supervision until team mtg (meeting) to develop guidelines and plans." Individual #1's record did not include documentation regarding why it was necessary for her to be "immediately placed on arm's length enhanced supervision" on 6/14/06, as her record documented she was already on arm's length supervision on 6/3/06 as a result of the "close proximity" supervision failing to keep her safe. Individual #1's record did not contain documentation that her level of supervision (close proximity versus arm's length) had changed from	W 127		

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W 127	Continued From page 11 6/3/06 to 6/14/06. - Individual #1's Enhanced Supervision Plan, dated 6/14/06, stated the desired outcome for enhanced supervision was to prevent Individual #1 from harming herself by cutting or re-opening wounds and eating non-edible items. The Plan stated she was on close proximity when in the day hall, her bedroom (awake and sleeping), and bathroom (during toileting and showering). She was arms-length when she was in the kitchen, walking outside, and when she began talking about baby dolls, devils/demons, or when she stated she was feeling anxious/stressed. A Temporary Informed Consent, dated 6/14/06, stated Individual #1's BSP went through the BRC on 6/13/06 and was scheduled to go to the HRC for approval on 6/23/06. "The team is seeking consent to implement the BSP today in an effort to prevent [Individual #1] from injuring herself and others." The BSP included the following instructions to staff regarding room searches: Under the section titled Instructions for Targeted Behaviors for Room Searches/Removal of Dangerous Items, it stated room searches were to be conducted randomly unless Individual #1 was on suicide watch and it was automatic. "Staff will search all areas where [Individual #1] can conceal items that she may cut herself with. Examples of items that could be inserted [sic] include pop can caps, pills, razors, glass, broken cd cases, nails, unattached zippers, paper clips, pens/pencils, scissors, knives, plastic utensils, medication, miscellaneous sharps or poisons (this includes hygiene items such as perfume or body sprays)...Remove items that [Individual #1] may be able to cut, overdose on, or swallow that are	W 127		

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W 127	Continued From page 12 unsafe...Document that a room search was completed on her behavior reporting form. Document what items were removed during the room search on the room search form...Items will be kept in the [unit] storage area so that [Individual #1] may have access to use the items with supervision." The BSP stated staff could remove items without completing a room search if "they believe it is something [Individual #1] is able to eat or cut herself with." -7/4/06 at 5:00 p.m.: An entry in the unit's communication log stated Individual #1 was outside and "She started yelling that she was going to kill herself and she wanted staff to call the police that she was going to commit suicide when the cops took her to jail. This lasted about 40 plus minutes till she started breaking plastic and stuck a piece in her mouth where she chewed it up and swallowed it." A corresponding OPFR Charting note, dated 7/6/06, stated "client ate/chewed upper part of a plastic spoon on 7/4/06." Individual #1's record did not include information related to how she obtained the plastic spoon or why staff did not intervene to remove the spoon. - 7/7/06: An SER stated Individual #1 was at the mini theatre and chewing her fingernails and "also said she chewed scab off her elbow." An investigation, dated 7/11/06, documented that Individual #1 filed a complaint against staff alleging staff were not keeping her safe. Individual #1 reported her staff was talking to other staff and Individual #1 asked to talk with her. Individual #1 stated her staff person was not listening and made no attempt to stop her when	W 127		

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W 127	Continued From page 13 she was chewing the skin off her finger. Individual #1 also reported a similar scenario with another staff when they went to a theatre. The staff was involved with the movie and not watching what Individual #1 was doing to herself. An OPFR Charting note was attached to the investigation and stated Individual #1 came to the nursing station at 9:30 p.m. and her ring finger of her right hand was bleeding. Individual #1 told the nurse "I am biting the skin off my fingers and it's because I like the taste of it. I have done this since I was four yrs. old it's just part of my life." The OPFR Charting note stated Individual #1 returned to the nursing station at 9:40 p.m. with the left pointer finger bleeding and "said once again she liked it. But also that seeing fire sets her off (lighting of cigarettes) she states @ this time she feels like cutting. [Individual #1] lifted up her sleeve and showed me her left elbow she states she bit the scab off while @ the mini theatre." An ABC sheet was attached to the investigation. The ABC sheet was dated 7/7/06 and the time was documented as "between 7:00 and 8:50 p.m." The ABC sheet stated "[Individual #1] said she was biting her nails. She was outside, showed me her finger - it was all bloody - showed me it was her finger. She bit a lot of skin off while watching a movie, she stopped when staff Q'd (cued) her." A second entry on the ABC sheet documented it was 9:40 p.m. and Individual #1 picked the side of her pointer finger. The 7/11/06 investigation's "Analysis of Findings" section stated "[Individual #1's] Behavior Service Plan for (SIB) and Enhanced Supervision Plan has them [the staff] watching for cutting on herself among other things. Staff did ask her to stop biting her nails but this is not addressed as SIB.	W 127		

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W 127	Continued From page 14 Therefore neglect is not founded because staffs [sic] were either arms [sic] length or in close proximity at all times. [Individual #1] felt that staff [staffs' names] may have been paying more attention to the movie, visiting with other staff and clients and did not feel she was getting the attention she wanted, therefore made the complaints." The Administrative Directors "Action to be Implemented" section of the report stated Individual #1's IDT was "to ensure adequate data and interventions for new behaviors (picking and biting skin)." Evidence of completion was to be placed in the file by 7/31/06. - 7/8/06 on "Swing" Shift: An entry in the unit's communication log stated "Have cued [Individual #1] not to chew her nails and fingers. So far she is listening to cues. [Individual #1] asked if she could have something to eat to keep from biting her nails/fingers. I gave her sugar free gum and told her we would give her 1 piece of candy or gum per hour until we talked with [QMRP] about helping her not to chew on her fingers/nails. She agreed this would help her, though she would rather have ice cream." -7/14/06: An entry in the unit's communication log stated "[Individual #1] had commented to her staff [name of staff] at 9:35 p (p.m.) that another staff from day shift had told her the way she is cutting herself will not kill her; the way you cut yourself is suppose to be vertical across veins not horizontal. [Staff] let her charge [staff] know about her incident with day staff." No documentation related to action taken by the facility as a result of the above mentioned entry could be found.	W 127		

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W 127	Continued From page 15 - 7/14/06 at 3:49 p.m.: An SER stated "Upon arrival home [Individual #1] and 1:1 staff walked in. Staff stopped at desk as [Individual #1] walked towards room. I got up to walk towards [Individual #1] as staff said who's [Individual #1's] 1:1 now as we both walked towards room. She was in room washing hands." An ABC sheet was attached to the SER and stated Individual #1 had re-opened an old sore "by biting it off." The SER stated Individual #1 reported it happened on the van ride home "But other [sic] feel it had happened when she was in bedroom for the few seconds." An OPFR Charting note was attached to the SER and stated "[Individual #1] reopened old cut area on left forearm. Area is now 5 cm x 1.5 cm full and partial thickness to old scar bed." The OPFR Charting note also contained an entry written by the QMRP which stated "Spoke with AOD (Administrator on Duty) regarding unattended time [Individual #1] potentially had earlier in the shift. Staff have been re-trained the [sic] emphasis of being Arms Length/Close Proximity depending on the situation/location of [Individual #1]." The facility failed to ensure Individual #1 received appropriate supervision necessary to keep her from harming herself. - 7/16/06 at 2100: An OPFR Charting note documented that during medication pass, the LPN noted "Frank blood to bilateral thumbs. [Individual #1] admits to chewing and biting nails states she is nervous and worried but will not expound on subject. Also states it is her right to hurt self or bite her self."	W 127		

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W 127	Continued From page 16 - 7/23/06 at 6:50 p.m.: An SER stated Individual #1 drank 14.8 ounces of body spray and engaged in self-injurious behavior. An ABC sheet was attached to the SER and stated Individual #1 requested to see the nurse and reported to her that she had an upset stomach and drank 14.8 ounces of body spray. An OPFR Charting note was attached to the SER and stated "Client requested to talk with nurse and report she was feeling dizzy. She reported that she drank some perfume and mouthwash in her bathroom. She also reported that she tried to cut her arms. She showed me her wrists and they had blood on the arm bands. She reported that she also drank the body gel in another bottle. She gave me the knife. It was a butter knife. She retrieved the items she claimed to drank [sic]. One bottle was 14 oz. of body spray, the second was 2 oz. of bath and shower gel, and 3rd was approximately 8 oz. of mouthwash...right forearm 2 in x ¼ inch scratch from knife, left forearm - dime-size abrasion from rubbing knife...1:1 supervision continues." An investigation into the incident, dated 8/1/06, contained an interview with Individual #1 who stated the bath products were in her room and she got the knife from a kitchen drawer when staff turned their heads. The investigation contained an interview with an LPN who stated Individual #1 reported to her (the nurse) that she (Individual #1) had just drunk a bottle of perfume, mouthwash, and some body gel. Individual #1 also reached into her pocket and produced a bloody kitchen knife wrapped in a washcloth. Individual #1 reported to the LPN that she was dizzy and feeling sick to her stomach. The investigation also contained interviews with two direct care staff who were assigned to Individual #1. One staff reported she noticed	W 127		

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W 127	Continued From page 17 toiletries on a shelf in Individual #1's bathroom room and she told Individual #1 she would only allow her to go into the bathroom alone if Individual #1 would continue to talk to her and if she could leave the door open. The second staff reported she returned to relieve the first staff and Individual #1 was just getting out of the shower. The second staff reported the door was open and she could see all of Individual #1's 'shower stuff' on the floor of the shower by her feet. The second staff reported after Individual #1 got dressed, she moved some of her body products from the shelf over by the sink, then used the toilet. The second staff reported she did not have a good view of Individual #1 when she was on the toilet as she (the staff) partially closed the door to allow for privacy. The second staff reported that around 4:35 - 4:40 p.m., she asked to be relieved so that she (the staff) could take a break and that Individual #1 was on the toilet complaining that she had diarrhea. The second staff reported that she was with Individual #1 during dinner time as well and never saw her (Individual #1) get into a drawer for anything. A Physician's Order, dated 7/23/06, stated Individual #1's guardian was contacted and "He wants her to have security camera at all times on her." The investigation's "Analysis of Findings" section stated "According to [Individual #1's] Enhanced Supervision Plan, staff is instructed to be in close proximity which is 20 ft. away and able to intervene within 10 seconds. Staff assigned to [Individual #1] was in compliance with this plan while allowing her privacy in the bathroom." The investigation report further stated "It is also unclear as to when or where [Individual #1]	W 127		

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W 127	Continued From page 18 obtained the butter knife. There are three testimonies that indicate [Individual #1] was in constant supervision not only from her 1:1 staff but other staff that were present at the times she was in the kitchen. The staff testimonies point out that [Individual #1] was never near the drawer where the knives were kept...[Individual #1] is capable of planning far in advance and could have procured the knife anytime prior to the day in question." The facility failed to ensure Individual #1's Enhanced Supervision plan was sufficiently developed to reflect the QMRP and Clinician's understanding that close proximity included visual supervision at all times (including visual supervision in the bathroom) as stated during an interview on 8/24/06 from 9:30 - 11:05 a.m. Additionally, it was not clear how the "random" room searches were effective in preventing Individual #1 from keeping items she could harm herself with if she had "procured the knife anytime prior to the day in question" as stated in the 8/1/06 investigation report. The facility failed to ensure Individual #1's program structure and supervision were sufficient to keep her from obtaining and using items to harm herself. -7/23/06: An entry in the unit's communication log stated "[Individual #1] is not to be alone even in the bathroom. Remove all all [sic] solutions or ingestible items." - A Physician's Order, dated 7/26/06, stated Individual #1's left forearm wound swab grew MRSA (methicillin resistant Staphylococcus aureus is used to describe those examples of this organism that are resistant to commonly used	W 127		

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W 127	Continued From page 19 antibiotics). Contact isolation was instituted and Individual #1 was restricted to her room. - 7/24/06: An entry in the unit's communication log stated "At 12:00 noon [Individual #1] had a 2:1 ratio. She was trying to reopen wrist injuries and running away from staff." - 7/29/06: An entry in the unit's communication log stated "[Individual #1] has been watching movies all day. She insists on having R rated movies or movies about little kids. [Individual #1] does have a plastic spoon that she had since she got a snack...[Individual #1] asking for gum so she won't chew her nails." - 7/30/06 at 2:16 p.m.: An SER stated Individual #1 started chewing the inside of her cheek causing it to bleed. An ABC sheet was attached to the SER and stated she was "spitting blood all over her room and on staff, she was also trying to leave her room at the same time. At first she was laughing at staff in between spitting. Then she started yelling that she was going to kill herself." An OPFR Charting note was attached to the SER and stated Haldol 10 mg, Benadryl 50 mg, and Ativan 2 mg were administered IM "secondary to blood spitting." - 7/30/06: An entry in the unit's communication log stated "[Individual #1] is not to have shampoo, lotion, body wash etc. in her room. Staff will get items put in small plastic cup for her. Items are in storage room." - An Interdisciplinary Progress Note, dated 7/31/06, stated "Team met regarding concerns with SIB that occurred on 7/30/06 at change of	W 127		

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W 127	Continued From page 20 shift a staff incident happening...Once she is in a physical restraint a chemical will be obtained until her BSP is approved by HRC a temporary consent can be obtained should this course of action be needed...Criteria will be set up for her to earn walks outside with 2 staff preferably 3x/day. When she takes these walks, [Individual #1] must wear long sleeved shirts, mask to face (due to MRSA)...Chemical restraint of Haldol 10 mg, Benadryl 50 mg, Ativan 2 mg to be given as her prn over a 24 hr (hour) period not to exceed 3 doses of this." A corresponding entry in the unit's communication log stated "[Individual #1] is close proximity at all times. Guidelines being put together for earning walks with 2 staff 2 -3 times day. When this occurs she will need to have on long sleeve shirt and face mask. She has been given a lot of videos we have in the classroom to use in her room. Sparquet (a disinfectant) to be used to disinfect and remove from room." Individual #1's record did not include documentation regarding why she was to be on "close proximity at all times" as her 6/14/06 Enhanced Supervision Plan stated she was on close proximity when in the day hall, her bedroom (awake and sleeping), and bathroom (during toileting and showering). She was arms-length when she was in the kitchen, walking outside, and when she began talking about baby dolls, devils/demons, or when she stated she was feeling anxious/stressed. Her record did not contain evidence that her level of supervision had changed from 6/14/06 to 7/31/06. - 8/1/06: Individual #1's BSP, revised 7/25/06 and implemented on 8/1/06, included the aforementioned instructions for room searches	W 127		

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W 127	Continued From page 21 and stated the following: "If [Individual #1] has a non-edible object small enough to eat or drink or an item with a sharp point or edge, staff will ask [Individual #1] to surrender the item. If she does not surrender the item staff will ask her to trade for a more preferred object. Staff will remove the item from [Individual #1]. If she assaults or attempts to injure herself proceed to HIS." - 8/4/06 (no time indicated): A Room Search Record showed sunscreen, broken piece of plastic from a CD case, and foaming hand sanitizer were found in Individual #1's room. A corresponding "Day" Shift entry in the unit's communication log stated "Clients are not to give items to each other. [Individual #16] gave [Individual #1] a couple of CD's and she tried cutting/scratching self...just a reminder that she is close proximity...no foam cleanser in her bathroom - she's to wash hands with soap and water - also removed plastic pop bottle from bathroom trash - all drinks should be poured into plastic cup...[Individual #1] targeting [Individual #12] few red marks on right arm from SIB biting self...[Individual #1] very upset with staff about room search. Sunblock removed." An 8/4/06 "Swing" Shift entry in the unit's communication log stated "all sharp items removed...Per AOD was able to leave TV. [Individual #1] was put into a prone. She for no apparent reason spit bodily fluids at staff. SER done for injury (SIB). Room cleaned of all breakables...During room clean [sic] found body spray in her room. Please make sure she is not left with and [sic] chemicals in her room. Also no plastic cups left in her room. Toothbrush needs to be kept out of bathroom near door."	W 127		

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W 127	Continued From page 22 An investigation into the 8/4/06 incident, dated 8/8/06, contained an OPFR Charting note which documented that on 8/4/06 at 10:26 a.m., Individual #1 reported to the nurse that "she has been having nightmares past 3 nights - last night about Chuckie - previous ones about drowning. She voluntarily handed over a broken CD case which she used. She stated the night mares 'stressed' her out...right forearm noted linear reddened scratch along forearm...I noted alcohol foam cleanser which I removed as well as plastic pop bottle in trash. Inserviced staff present...no ingestible items to be in her bathroom per BSP - also notified not to have plastic items she can break and use to cut herself." The investigation also contained an OPFR Charting note which documented that on 8/4/06 at 2:45 p.m. Individual #1 was taking her medications and requested to speak with the nurse in private. Individual #1 gave the nurse a piece of plastic approximately 2 inches long by ½ inch wide with dried specks of blood on it. Individual #1 told the nurse "I had a nightmare last night and used it to cut myself with it." Individual #1 showed the nurse her left forearm which contained "1 cm long by ½ cm wide, numerous (@ least 3-4) superficial scratches to outside of wound...Per [Individual #1] she got the CD from [another individual] last week on pm's/evenings. At 1300 [a direct care staff] brought sunscreen from [Individual #1's] room..." The facility failed to ensure Individual #1 received appropriate supervision necessary to keep her from obtaining and using items to harm herself. Additionally, Individual #1 reported she had the above mentioned CD for a week. The item had not been found during the "random" room searches.	W 127		

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W 127	Continued From page 23 - 8/5/06: An entry in the unit's communication log stated "[Individual #1's] personal hygiene items are not to be in her room. They are to be kept in the storage room and taken to room in med cups...Do not keep DVD or CD's in [Individual #1's] room. When she is finished with them, remove from her room in a plastic bag, give to nursing." - 8/6/06: An entry in the unit's communication log stated "We need to do weekly, at least, room checks on [Individual #1]. This includes doing the room search forms. Please have a female present when doing this." - 8/7/06 "AM" Shift: An entry in the unit's communication log stated "[Individual #1] pissed off mood refusing male nurse to wrap arms had to restrain [Individual #1's] arms she was biting herself I think [Individual #1] has been chewing on her cheeks today. She said lastnight [sic], she had dreams showing/teaching her how to hurt herself. She said her brain makes it to where she wants infections and she wants to chew/bite the gaps out of her skin." - 8/7/06 (no time indicated): An entry in the unit's communication log stated "[Individual #1] continues on close proximity. CD's/DVD's will be immediately removed when she is finished with them. Do not leave in room! Arms/hands are to be visible at all times. If she does not comply, she is arms length." A "Swing" Shift entry in the unit's communication log stated "Nurse gave [Individual #1] a pack of gum - she said [Individual #1] could have one piece every 2 hrs (hours)...putting ice on hand that she bit on day	W 127		

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W 127	Continued From page 24 shift...[Individual #1] said she bit herself again in the same place on her hand but two staff were with her at the time and didn't see her put her hand to her mouth and now she has to keep her hands where staff can see them. Also the spots didn't look any different than when she showed them to staff earlier in the shift." Further, an Interdisciplinary Progress Note, dated 8/7/06, stated "Team met to discuss concerns with her enhanced supervision level...Team agreed that she needs to have her hands visible at all times, will continue close proximity. If she does not agree to having hands visible staff will place on arms length. CD's and DVD's will be made available, but staff will remove when she is finished watching/listening to. Clinician will f/u (follow up) to see if she can be masked if she begins spitting." Individual #1's record did not include documentation regarding why she was to continue "close proximity" as her 6/14/06 Enhanced Supervision Plan stated she was on close proximity when in the day hall, her bedroom (awake and sleeping), and bathroom (during toileting and showering). She was arms-length when she was in the kitchen, walking outside, and when she began talking about baby dolls, devils/demons, or when she stated she was feeling anxious/stressed. Her record did not contain evidence that her level of supervision had changed from 6/14/06 to 8/7/06. - 8/8/06 at 7:45 p.m.: An SER stated Individual #1 was watching "Lethal Weapon" in her bedroom with staff observing. An ABC sheet was attached to the SER and stated "At the beginning of the movie there was a scene where Mel Gibson [sic]	W 127		

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W 127	Continued From page 25 "character" put a gun in his mouth...When the gun was in his mouth she said she wanted to do that." - 8/8/06: An entry in the unit's communication log stated "[Individual #1] saying since we took all her cutting items shes [sic] now going to bite herself to death. She said from now on shes [sic] going to use her teeth to hurt herself...[Individual #1] trying to chew a hangnail on her left hand. Qed (cued) to stop she said she would just do it tomorrow then." Her Enhanced Supervision Plan, revised 8/9/06, stated she was on close proximity when in the day hall, her bedroom (awake and sleeping), and bathroom (during toileting and showering). She was arms-length when she was in the kitchen, walking outside, and when she began talking about baby dolls, devils/demons, or when she stated she was feeling anxious/stressed. When at arms-length, staff were to see her hands. If staff could not see her arms/hands at close proximity, staff were to remain arms-length. If she was unwilling to allow staff to see her arms/hands, staff were to remind her that staff must be within arms-length. - 8/10/06 (no time indicated): A Room Search Record showed a photo album with metal spiral rings was found in Individual #1's room. A corresponding entry in the unit's communication log stated "please make sure that pulled staff from other bldgs (buildings) are not working with [Individual #1]. They have not been trained on her program and the less people we have working around MRSA the better...[staff] removed a purple photo album with metal spiral ring holding the book together."	W 127		

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W 127	Continued From page 26 An Interdisciplinary Progress Note, dated 8/11/06, stated "It was noted today in HRC that the committee does not feel she is appropriately placed. The committee made reference to the comprehensive Psychiatric Evaluation dated 6/2/06." - 8/11/06 (no time indicated): A Room Search Record showed 2 CDs, 1 ink pen, 1 toothbrush, 1 tube of toothpaste, and 1 bar of soap were found in Individual #1's room. - 8/11/06 at 8:30 p.m.: An SER stated Individual #1 "was able to keep a plastic spoon in her room overnight." An OPFR Charting note was attached to the SER and stated Individual #1 showed a staff her upper left forearm stating she (Individual #1) used a plastic spoon to cut herself on night shift. An ABC sheet was attached to the SER and stated "She told me that at 1 am (1:00 a.m.) when staff was talking she cut it with a broken plastic spoon." The facility failed to ensure that on 8/11/06 Individual #1 received appropriate supervision necessary to keep her from obtaining and using items to harm herself as specified in her Enhanced Supervision Plan revised 8/9/06 (constant visual on her arms/hands at all times). Additionally, the "at least weekly" random room searches were ineffective in preventing Individual #1 from keeping items she could harm herself with. - 8/12/06: An entry in the unit's communication log stated "It has been approved by the AOD for [Individual #1] to have her TV back. - 5:17 p.m. -	W 127		

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W 127	Continued From page 27 [Individual #1] is still on suicide watch, but it's been modified to 20 feet technically level 2 - close proximity." - A Physician's Order, dated 8/15/06, stated Individual #1's oral pharynx culture came back positive for MRSA. Room restrictions with contact isolation were to continue. - A Physician's Order, dated 8/16/06, stated Individual #1 "is colonized with MRSA in the oral pharynx. There is a 10% chance of spread. However, she has frequently spit on others which increases the risk of transmission...she doesn't have active MRSA infection. Will continue contact isolation until de-colonization secondary spitting." - 8/16/06 at 6:50 p.m.: An SER stated Individual #1 lifted her right hand and a staff noticed she had wrapped tape around her fingers and was cutting off circulation. An ABC sheet was attached to the SER and stated Individual #1 told staff that she wrapped her fingers with the tape (a medical dressing) from her arm. Individual #1 lifted her right hand and showed staff that she had wrapped her "middle and right index finger with white tape from one of the wounds on her arm so tight that the fingers turned purple. She then made the comment 'I am going to kill myself'." A Room Search Record, dated 8/16/06, was attached to the SER and documented hangers, a television, shoes with shoe laces, a phone charger, scrap paper, and a hat were removed from her room due to "threats of pica." A corresponding entry in the unit's communication log stated "[Individual #1] was watching tv, removed tape from arm and wrapped it around	W 127		

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W 127	Continued From page 28 her hand and cut off circulation to her hand. Staff tried to help by trying to remove tape from hand. She would not let staff. Went into a two person sit. Afterward she removed tape herself. Said she was going to harm herself. QMRP was here, she heard it all. Said to go ahead and remove all dangerous items from her room. Two person sit had to go into prone during cleaning. This was around 6:50 p.m. Second HIS prone at 7:45 p.m. Chemical was allowed to use [sic]. Placed on suicide watch, arms length." The facility failed to ensure Individual #1 received appropriate supervision per her Enhanced Supervision Plan revised 8/9/06 (constant visual on her arms/hands at all times), necessary to keep her from wrapping the tape around her fingers to cut off the circulation. - 8/17/06: An entry in the unit's communication log stated "[Individual #1] may have items back in her room that she can not injure self with and return to enhanced supervision as on individual schedule...analize [sic] all items for possible sharp edges and cords." - 8/18/06 "Day" Shift: An entry in the unit's communication log stated "2 CD's and a video tape was [sic] taken out of [Individual #1's] room. We are to give her 1 CD or movie at a time, and get it right back from her when she's done." The facility failed to ensure Individual #1 received appropriate supervision/intervention necessary to keep her from keeping items she could harm herself with. - 8/21/06 at 11:30 a.m.: A Room Search Record	W 127		

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W 127	Continued From page 29 showed 1 large yellow envelope with a metal clasp was full of paper, 2 Rubbermaid lids from her storage tubs in the storage room, clothing on hangers, a tube of Chapstick, 2 pieces of broken CD pieces, 2 plastic med cups, and 1 plastic spoon were found in Individual #1's room. A corresponding "Day" Shift entry in the unit's communication log stated "Shampoo and shower accessories and a CD were left in [Individual #1's] room. Any CD's are to be removed when [Individual #1] is done with them. All med cups for showering needs need to be thrown away immediately after use...Room search completed with [Individual #1]. The following items were removed from her room: plastic spoon, 2 plastic med cups, 4 sm (small) pieces from a broken CD, 1 lg (large) envelope with metal clasp, 1 chapstick tube with plastic top, 2 rubbermaid lids, hangers. [Staff] has been notified to take out [Individual #1's] lock box and metal shower hanger, since she made the comment she does not feel safe with them. Will also pad the metal hardware on door frame. [Staff] will be picking up a clear shower curtain. [Individual #1] stated she took staples from area outside door, staff not watching. This is serious everyone!! Items found in room should not have been found. 1:1 guidelines must be followed." - 8/21/06 at 12:00 p.m.: An SER stated Individual #1 showed the LPN scratches to her left arm. An OPFR Charting note was attached to the SER and stated Individual #1 showed the LPN "large area approximately 10 cm long x 4 cm wide, top et underside of forearm with superficial scratches et previous 1/8 cm open area now ½ cm x ¼ cm ...[Individual #1] stated 'I did it last night. I used some staples' - handed nurse x2 staples - 'et I	W 127		

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W 127	Continued From page 30 pulled the metal off the top of the mask' - gave nurse old bright blue mask from under her mattress - 'I did it while I took my shower last night' - Dressing in shower - 'et I put the metal piece down the shower drain.' Nothing visible. Stated 'I'm going to crack my head on the door jam I just want to hurt myself, or I've used shoe strings before to try and strangle myself but I'm not going to do that because it hurts'...Room search initiated." The SER stated "Room search done with plastic spoon/CD's etc...removed." An investigation of the incident, dated 8/23/06, documented "the lack of room searches documented by staff for a five day period prior to the discovery of banned materials from the client's room following the incident..." The facility failed to ensure that on 8/21/06 Individual #1 received appropriate supervision necessary to keep her from obtaining and using items to harm herself as specified in her Enhanced Supervision Plan revised 8/9/06 (constant visual on her arms/hands at all times). Additionally, it was not clear how the "at least weekly" random room searches were effective in preventing Individual #1 from keeping items she could harm herself with. -8/22/06 on "Days" Shift: An entry in the unit's communication log stated "[Individual #1] said when she was a child she would hit, bite, scratch other little kids she also said if [staff] or anyone else came near or in her room she'd give them Mersa [sic] she also said she used to be in a gang and shes [sic] shot people. [Individual #1] also said the devil and his demons tell her to hurt herself and others [Individual #1] also said she can see the devil and his demons she also says	W 127		

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W 127	Continued From page 31 they visit her at night and she said if she doesn't do what they say then they will hurt her. [Individual #1] says night shift staff left her unattended for at least 5 min to attend another client situation. [Individual #1] stapled staples into her arm. [Individual #1] gave the nurse two staples. [Individual #1] said she took a pen off the drawr [sic] station next to her room she said she took the pen and drank some of the ink and put the rest in her arm. [Individual #1] said "shes [sic] had training on how to kill people she said she was taught how to break peoples neck, bones and that she felt like breaking all the clients noses. [Individual #1] also said [Individual #17] better watch it because shes [sic] sick of all of her teasing. [Individual #1] said she could beat the shit out of all the staff except [a male staff] and [Individual #1] also said shes [sic] going to cut her self on the lights and the doors she also said shes [sic] going to put her fingers in the electrical sockets and she had staff remove the plastic sacks from her room because she said she could do something terrible to herself with them. [Individual #1] had staff remove the hangers from her room because she said she would break them and hurt someone mainly staff." No documentation related to action taken by the facility as a result of the allegation (that night shift staff left her unattended for at least 5 minutes to attend to another client situation) could be found. - 8/22/06 "Day" Shift: An entry in the unit's communication log stated "Effective immediately (Per AD) when you switch out staff for [Individual #1's] 1:1, room search is to be completed (No exceptions). ALL SHIFTS must complete the daily assignment sheet and Enhanced	W 127		

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W 127	Continued From page 32 Supervision form. Everyone will be held accountable...Whenever staff give [Individual #1] magazines make sure there are no staples in them...Room search initiated at 10a (10:00 a.m.) and many items with staples removed. There are to be no items with staples in room (notebook, magazines, binders, etc.)." Individual #1's BSP was modified to state room searches were to be conducted every two hours. Her 8/22/06 Room Search Records documented the following times room searches were conducted and items that were found: - 10:00 a.m.: Titanic DVD, multiple pamphlets with staples, a stuffed animal with a metal chain, 2 VHS movies, 3 tablets with staples, and 7 staples in documents. - (No time indicated): a notebook with metal and 2 magazines with staples. -"NOC" Shift: An entry in the unit's communication log stated "did room search found one hat metal clip...removed her cell phone charger was plugged into wall has metal tip on it plus metal plug ins." The documentation did not support that room searches were being conducted every 2 hours as specified in her 8/22/06 BSP revisions. Additionally, potentially harmful materials continued to be found during each room search. Since her admission, Individual #1 continued to obtain and use items to hurt herself. When asked during an interview on 8/24/06 from 9:30 - 11:05 a.m., how Individual #1 continued to obtain items and hurt herself given her enhanced supervision,	W 127		

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W 127	Continued From page 33 the QMRP and Clinician stated "that's a good question." Given Individual #1's history, the lack of adequate supervision and continued incidents of self harm, and the lack of program structure, the potential for serious harm was present for Individual #1. Note: The facility provided a plan of correction, dated 8/25/06, documenting revisions and staff training on Individual #1's Enhanced Supervision Plan and BSP. Due to Individual #1's hospitalization on 8/25/06 for an unrelated medical condition, the immediate jeopardy was abated on that date. Individual #1 returned to the facility on 9/5/06. An on-site visit was conducted on 9/7/06 to ensure the immediate plan of correction was implemented.	W 127		
W 128	483.420(a)(6) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals were free from unnecessary drugs and physical restraints for 1 of 7 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in potential negative impacts to an individual's well being. The findings include:	W 128		

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W 128	Continued From page 34 1. Individual #1's PCP, dated 6/20/06, documented an 18 year old female diagnosed with mild mental retardation, schizoaffective disorder bipolar type, oppositional defiance disorder by history, borderline personality disorder, gastroesophageal reflux disease (refers to the clinical manifestations of reflux of stomach contents into the esophagus), and gallstones. She was admitted to the facility on 5/22/06. A Physician's Order, dated 7/23/06, stated cultures were to be obtained from Individual #1's nose, oral pharynx, and any open wounds and "Restrict to unit - may go outside on unit. No swimming." A Physician's Order, dated 7/26/06 stated Individual #1's left forearm wound swab grew MRSA. Contact isolation was instituted and Individual #1 was restricted to her room. A Temporary Informed Consent, dated 8/7/06, stated "[Individual #1] was recently diagnosed with MRSA requiring staff to use universal precautions. [Individual #1] has been engaging in spitting behavior which puts those not wearing protective gear at risk for infection. In an effort to protect the health and safety of [facility] clients and staff when [Individual #1] [sic] the team is seeking consent to place the protective mask over [Individual #1's] mouth. Times that this would be necessary include: when [Individual #1] is on a walk on campus refusing to wear a mask and begins spitting towards others; and times that [Individual #1] is in a physical restraint and spitting at others that are not wearing protective gear (gowns, gloves, goggles etc). Staff will ask [Individual #1] to wear mask, but if she refuses to do so, staff will place the mask on for [sic] her	W 128		

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W 128	Continued From page 35 during theses times. The mask will not be placed on [Individual #1] when she is in her room and the staff are already wearing protective gear." The facility's Significant Event Reports (SER) and Individual #1's OPFR Charting notes, dated 7/30/06 - 8/11/06, documented the following physical and chemical restraints for spitting behavior. - 7/30/06 at 2:16 p.m.: An SER stated Individual #1 started chewing the inside of her cheek causing it to bleed. An ABC sheet was attached to the SER and stated she was "spitting blood all over her room and on staff, she was also trying to leave her room at the same time." An entry in the unit's communication log, dated 7/30/06, stated "[Individual #1] was chewing tongue and cheeks, began spitting into a cup. I started watching and blood was being spit in cup. I started questioning [Individual #1] about blood. [Individual #1] said "It's none of your damn business." I alerted [staff] that [Individual #1] was spitting blood. She then poured it on my ankle. She said "You deserve it b/c (because) you are giving me 'the look'. [Staff] came in and started restraint." An OPFR Charting note, dated 7/30/06, stated she was placed in a prone restraint and continued to spit blood at staff. A surgical mask was placed over her mouth and the QMRP was consulted. "[QMRP] was agreeable to use chemical restraint and ok to give IM secondary to blood spitting." The OPFR Charting note documented Haldol 10 mg, Benadryl 50 mg, and Ativan 2 mg were administered IM at 2:55 p.m. - 8/4/06 at 7:10 p.m.: An OPFR Charting note stated Individual #1 threw what appeared to be	W 128		

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W 128	Continued From page 36	W 128		

blood/saliva on a staff resulting in a prone restraint from 7:15 - 7:35 p.m. The doctor was called for a chemical restraint and at 7:20 p.m., Haldol 10 mg, Benadryl 50 mg, and Ativan 2 mg were administered IM due to "blood spitting."

- 8/11/06 at 9:15 p.m.: An OPFR Charting note stated Individual #1 stated "chewing of inside of mouth and oral bleeding." The doctor was called for a chemical restraint and at 9:20 p.m., Haldol 10 mg, Benadryl 50 mg, and Ativan 2 mg were administered IM. A Physician's Order, dated 8/11/06, stated "HIS restraint chewing of mouth with bleeding...chemical restraint given."

As noted above, the mask was utilized one time (7/30/06) for spitting and there was no evidence in Individual #1's record that the mask was not effective. When asked why Individual #1 was receiving chemical restraints for spitting, the QMRP and Clinician stated during an interview on 8/24/06 from 9:30 - 11:05 a.m., they were not aware of that.

The facility failed to ensure the use of chemical and physical restraints were based on Individual #1's need and the spitting behavior could not be addressed by other means.

Further, Individual #1's BSP, dated 6/23/06 and revised 7/25/06, included a section titled Instructions for Targeted Behaviors for Chemical Restraint Criteria which stated "When [Individual #1] is going into a physical restraint, contact a profession [sic] to assess for a chemical restraint. Chemical restraint to be used: Haldol 10 mg PO or IM and Benadryl 50 mg PO or IM and Ativan 2 mg PO or IM." When asked about calling for a

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W 128	Continued From page 37 chemical restraint as Individual #1 was going into a physical restraint, the QMRP and Clinician stated Individual #1 was typically in a prone restraint for 20 - 25 minutes and professionals were to assess the situation prior to the order. When asked how the assessment was conducted, the Clinician stated it was sometimes done in person and sometimes done over the phone. As stated, it would not be possible to assess whether a chemical restraint was necessary at the beginning of a prone restraint. 2. Refer to W313 as it relates to the facility's failure to ensure an individual was not subjected to unnecessary behavior modifying medications.	W 128		
W 133	483.420(a)(9) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure clients have the opportunity to communicate, associate and meet privately with individuals of their choice. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals were afforded freedom of movement for 1 of 7 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in potential negative impacts to an individual's well being. The findings include: 1. Individual #1's PCP, dated 6/20/06, documented an 18 year old female diagnosed with mild mental retardation, schizoaffective	W 133		

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W 133	Continued From page 38 disorder bipolar type, oppositional defiance disorder by history, borderline personality disorder, gastroesophageal reflux disease (refers to the clinical manifestations of reflux of stomach contents into the esophagus), and gallstones. She was admitted to the facility on 5/22/06. A Physician's Order, dated 7/23/06, stated cultures were to be obtained from Individual #1's nose, oral pharynx, and any open wounds and "Restrict to unit - may go outside on unit. No swimming." A Physician's Order, dated 7/26/06 stated Individual #1's left forearm wound swab grew MRSA. Contact isolation was instituted and Individual #1 was restricted to her room. An Interdisciplinary Progress Note, date 7/31/06 and signed by the QMRP, stated "Criteria will be set up for her to earn walks outside with 2 staff preferably 3x/day. When she takes theses walks, [Individual #1] must wear long sleeved shirts, mask to face (due to MRSA)." Individual #1's record contained a plan titled "Criterion For Going On A Walk." The plan was undated and stated "[Individual #1 will be able to earn 3 walks per day, one between 9am and 12pm, one between 12pm and 3pm and one between 3pm and 6pm. In order to earn her walk the following criterion must be met: 1) No behaviors such as scratching, picking, yelling at staff or manipulating staff for at least one hour prior to going out for the walk. 2) No statements about having behaviors for at least one hour prior to going for the walk ...If [Individual #1] has behaviors or there are issues during a walk then [Individual #1] will not be able to earn a walk during the next time period."	W 133		

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W 133	Continued From page 39 When asked about the plan, the QMRP stated during an interview on 8/24/06 from 9:30 - 11:05 a.m., the plan was put in place on 7/27/06. When asked why she had to earn walks, the QMRP stated it was due to her behavior. When asked about consents for the plan, the QMRP stated there were no consents. The facility failed to ensure Individual #1's freedom of movement was not restricted without justification and appropriate approvals and programs in place. 2. Refer to W262 as it relates to the facility's failure to ensure restrictive interventions were implemented only with the approval of the human rights committee. 3. Refer to W263 as it relates to the facility's failure to ensure restrictive interventions were implemented only with the approval of the parent/guardian.	W 133		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination of the status for 5 of 7 individuals (Individuals #1, 11-13, and #15) whose BSPs were reviewed. That failure resulted in	W 159		

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W 159	Continued From page 40 individuals not receiving the services and training required to meet their health, safety, and behavioral needs. The findings include: 1. Refer to W122 - Condition of Participation: Client Protections and related standard level deficiencies including W127 as it relates to the facility's failure to ensure the QMRP provided sufficient oversight to ensure individuals were not subjected to neglect or mistreatment. 2. Refer to W266 - Condition of Participation: Client Behavior and Facility Practice as it relates to the facility's failure to ensure the QMRP provided sufficient oversight to ensure individual programs were sufficiently developed, implemented, and monitored to meet the individuals' behavioral needs.	W 159		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on interview, it was determined the facility failed to ensure behavioral assessments were current, comprehensive, and accurately identified an individual's behavioral status and needs for 1 of 6 individuals (Individual #11) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program objectives and interventions. Findings include: Individual #11's PCP, dated 5/11/06, stated he	W 214		

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W 214	Continued From page 41 was a 21 year old non-verbal male, diagnosed with severe mental retardation, possible autism, seizure disorder by history, and multiple scars secondary to self-injurious behavior. During the facility's prior survey of 6/19/06, Individual #11's PCP contained a "Behavior Support Program," dated 8/30/05, to instruct staff as to how to intervene when he engaged in the self-injurious behavior of hitting his head. Individual #11's QMRP and Clinician were interviewed during the 6/19/06 survey on 5/22/06, from 11:10 a.m. - 11:55 a.m. and from 1:35 p.m. - 2:20 p.m. They were asked if staff were to intervene by blocking Individual #11's initial and subsequent hits to his head. They replied no, as doing so would escalate the behavior. Information was requested from the professionals to support that blocking Individual #11's hits to his head was tried systematically and demonstrated to be ineffective. The Clinician stated that a functional assessment had been completed which reflected their statement to be correct. The surveyor requested the functional assessment. The Clinician stated he had a summary of the assessment. He provided the surveyor a document titled "Summary of Conditions presented 8/12/04" (from the functional assessment) on 6/12/06. The summary read as follows: * "In these observations Biting self (SIB), slapping self (SIB) and hits to head (self stim behavior) was recorded. Biting self and slapping self would have been treated as the same but the slapping self did not occur." * Item #9 followed the above statement. It read -	W 214		

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W 214	Continued From page 42 "Task Demand/block---In this condition (Individual #11) was asked to do a task and when he bit/slapped himself the bit/slap was blocked." This statement contradicted the preceding one, as it said he had slapped himself. * The graph, contained on page 2 of the document, was labeled "Bites to Self." The first sentence after the graph stated the "graph reflects that (Individual #11) exhibits SIB (bites self) most often when asked to do a task and when the biting self if [sic] blocked the rate of biting self- increases. Leaving (him) alone, or not interacting with him decreases the rate of biting." * The statement which followed the statement above read, the "conclusion to the conditions presented is that SIB (biting/slapping self) is more likely to occur when he is ask [sic] to do a task and Blocking the SIB tends to increase the frequency of the SIB and also increases his attempts to assault Staff." This statement contradicted the preceding one, as it included slapping himself as part of the SIB behavior. The "Summary of Conditions presented 8/12/04," which reflected the outcome of Individual #11's above referenced behavioral assessment, did not support the QMRP's and Clinician's statements that blocking his hits to his head would escalate the behavior. No further assessment or supportive information was provided. The facility was cited at this standard during the 6/19/06 survey. The facility's credible allegation, dated 8/17/06, stated "assessments have been updated as needed to ensure they are current." On 8/21/06,	W 214		

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W 214	Continued From page 43 at approximately 2:50 p.m., Individual #11's QMRP was asked for his updated behavioral assessment. The QMRP stated one had not been done. Individual #11's Clinician confirmed on 8/22/06, at approximately 1:00 p.m., that the facility had not updated his behavioral assessment as specified in the facility's credible allegation.	W 214		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure written training programs provided clear and sufficient directions to staff on how to implement behavior programs for 2 of 7 individuals (Individuals #1 and 14) whose behavior support programs were reviewed. This resulted in the potential for inconsistent application of techniques being utilized. The findings include: 1. Individual #14 was a 25 year old female with diagnoses of bipolar disorder, post traumatic stress disorder, mild mental retardation and borderline personality. She was admitted to the facility on 4/5/06. a. Individual #14's BSP, titled Manage Mental Health, dated 4/06, included an objective for her to have fewer than five episodes of anger outbursts for three consecutive months. Anger outbursts were defined, in the data section, as	W 234		

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W 234	Continued From page 44 exhibiting two or more of the following behaviors within a fifteen minute period of time: verbal threats, loud voice, self-report of anger, self injurious behavior and destruction of property. Under the section titled "Instructions For Staff", it stated staff were to: "- Verbally block and redirect her by reminding her that she may take a break in a safe area. - Remind her that she may request to talk with staff if she needs to talk about something. - Remind her that she may use her weighted blanket to help calm. - Staff will record each episode of anger outbursts on the behavior reporting form. An episode is defined in the data section. - Staff will check the box for each behavior that occurred during the episode." The instructions did not include what to do if the behaviors continued to escalate when redirected, or what to do if staff were unable to talk with her when she requested. It was unclear how staff were to determine if Individual #14 was speaking in a loud voice. The instructions stated staff were to remind her she could use her weighted blanket, however, the instructions did not tell them when they were to remind her. Additional instructions, under DOP, stated staff were to remove the object she was destroying when possible. The instructions did not include how they were to take the item (verbal request, physically take the item, etc.). The instructions for SIB stated staff were to minimize attention but did not include when or how staff were to intervene to provide for	W 234		

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W 234	Continued From page 45 Individual #14's safety when she engaged in SIB. b. The BSP also included an objective for her to have fewer than five episodes of impulsivity for three consecutive months. Impulsivity was defined as two or more of the following behaviors within a fifteen minute time period: physical assault, suicide ideation, leaving without permission and interrupting staff. Under the section titled "Instructions For Staff", it stated: "- Staff will verbally block and redirect by reminding her she could take a break in a safe area. - Remind her she may request to talk with staff if she needs to talk about something. - Staff will record each episode of impulsivity on the behavior reporting form as defined in the data section. - Staff will check the box for each behavior that occurred during the episode." The instructions did not include what to do if the behaviors continued to escalate when redirected, or what to do if staff were unable to talk with her when she requested. The instructions for physical assault stated staff were to ensure safety to the target of the assault and to Individual #14. The instructions to staff did not include how to do this such as keeping the individuals separated, involving Individual #14 in another activity, etc. The facility was previously cited, on 6/19/06, at W234 (clear and concise instructions) for Individual #14. The facility's credible allegation,	W 234		

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W 234	Continued From page 46 dated 8/17/06, stated "Clinicians reviewed all BSPs, and revised as needed to ensure the accuracy of medication criteria, the clarity of instructions to staff,and that the status section is accurate and current to the last update." During interview, on 8/23/06 at 9:10 a.m., the Clinician stated the methods in the program had not been revised as stated in the facility's credible allegation. 2. Individual #1's PCP, dated 6/20/06, documented an 18 year old female diagnosed with mild mental retardation, schizoaffective disorder bipolar type, oppositional defiance disorder by history, borderline personality disorder, gastroesophageal reflux disease (refers to the clinical manifestations of reflux of stomach contents into the esophagus), and gallstones. She was admitted to the facility on 5/22/06. Individual #1's BSP, dated 6/23/06 and revised 7/25/06, included the following target behaviors and definitions: - SIB was defined as cutting on herself, banging her head, and scratching her body. - Physical Assaults was defined as spitting, smearing body fluids onto another person, hitting, kicking, or throwing objects at others. - Psychotic behavior was defined as hallucinations and delusions. Hallucinations were defined as seeing or hearing things that other people did not see or hear. Delusions were defined as talking about things that were bizarre, unreal, things that really did not occur, or suspiciousness related to an issue that was not happening. - Suicide Ideation was defined as any verbal or	W 234		

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W 234	Continued From page 47 written comment or statement made indicating Individual #1 wished to kill herself. If Individual #1 was making suicide statements and engaging in SIB and PICA at the same time, it was to be reported as a suicide attempt. - PICA was defined as eating or drinking something that was not edible. - Under the section titled Instructions for Targeted Behaviors for PICA, it stated staff were to "Remove the item she is trying to eat/drink when possible." The plan did not included instructions how items were to be removed from Individual #1. - Under the section titled Instructions for Targeted Behaviors for Room Searches/Removal of Dangerous Items, it stated room searches were to be conducted randomly unless Individual #1 was on suicide watch and it was automatic. "Staff will search all areas where [Individual #1] can conceal items that she may cut herself with. Examples of items that could be inserted [sic] include pop can caps, pills, razors, glass, broken cd cases, nails, unattached zippers, paper clips, pens/pencils, scissors, knives, plastic utensils, medication, miscellaneous sharps or poisons (this includes hygiene items such as perfume or body sprays) ...Remove items that [Individual #1] may be able to cut, overdose on, or swallow that are unsafe ...Document that a room search was completed on her behavior reporting form. Document what items were removed during the room search on the room search form ...Items will be kept in the [unit] storage area so that [Individual #1] may have access to use the items with supervision." The BSP stated staff could remove items without completing a room search if "they believe it is something [Individual #1] is able	W 234		

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W 234	Continued From page 48 to eat or cut herself with." However, instructions on the Room Search form stated "personal items or furnishings that are disturbed during the search are to immediately be replaced to their condition prior to the search." As stated on the Room Search form, items were not to be removed from Individual #1's room. - Under the section titled Instructions for Targeted Behaviors for Chemical Restraint Criteria, it stated "staff is unable to redirect [Individual #1] for 15 consecutive minutes from attempts to harm herself or others." When asked the definition of "redirect", the QMRP and Clinician stated during an interview on 8/24/06 from 9:30 - 11:05 a.m., it was verbal. When asked what behaviors were included in "attempts to harm herself or others", the Clinician stated cutting, scratching, pica, and assaulting. The Clinician stated assaulting included kicking, hitting, biting, and throwing items. The facility failed to ensure Individual #1's BSP contained contained sufficient instructions to staff.	W 234		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was	W 262		

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W 262	Continued From page 49 determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 2 of 5 individuals (Individuals #1 and 12) whose consents were reviewed. This resulted in a lack of protection of individual rights through prior approvals on restrictive interventions. The findings include: 1. Individual #12's PCP, dated 1/24/06, documented a 29 year old female diagnosed with schizoaffective disorder, obsessive compulsive disorder, mild mental retardation, history of borderline personality disorder, and insulin dependent diabetes mellitus. During an observation on 8/21/06 at 3:40 p.m., a direct care staff was interviewed regarding the level of supervision required for individuals living in the Birch 2 unit. He stated Individual #12 was on enhanced supervision when she was in her bedroom or bathroom, due to inserting items in her rectum. At 4:05 p.m. Individual #12 asked the QMRP to take her to the restroom. When asked, on 8/23/06 at 9:20 a.m., if HRC approval for restricting Individuals #12's privacy had been obtained, the QMRP stated the facility did not consider 1:1 a restrictive intervention and a consent had not been obtained. 2. Individual #1's PCP, dated 6/20/06, documented an 18 year old female diagnosed with mild mental retardation, schizoaffective disorder bipolar type, oppositional defiance disorder by history, borderline personality disorder, gastroesophageal reflux disease (refers to the clinical manifestations of reflux of stomach	W 262		

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W 262	Continued From page 50 contents into the esophagus), and gallstones. She was admitted to the facility on 5/22/06. A Physician's Order, dated 7/23/06, stated cultures were to be obtained from Individual #1's nose, oral pharynx, and any open wounds and "Restrict to unit - may go outside on unit. No swimming." A Physician's Order, dated 7/26/06 stated Individual #1's left forearm wound swab grew MRSA. Contact isolation was instituted and Individual #1 was restricted to her room. An Interdisciplinary Progress Note, date 7/31/06 and signed by the QMRP, stated "Criteria will be set up for her to earn walks outside with 2 staff preferably 3x/day. When she takes theses walks, [Individual #1] must wear long sleeved shirts, mask to face (due to MRSA)." Individual #1's record contained a plan titled "Criterion For Going On A Walk." The plan was undated and stated "[Individual #1 will be able to earn 3 walks per day, one between 9am and 12pm, one between 12pm and 3pm and one between 3pm and 6pm. In order to earn her walk the following criterion must be met: 1) No behaviors such as scratching, picking, yelling at staff or manipulating staff for at least one hour prior to going out for the walk. 2) No statements about having behaviors for at least one hour prior to going for the walk ...If [Individual #1] has behaviors or there are issues during a walk then [Individual #1] will not be able to earn a walk during the next time period." When asked about the plan, the QMRP stated during an interview on 8/24/06 from 9:30 - 11:05 a.m., the plan was put in place on 7/27/06. When	W 262		

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W 262	Continued From page 51 asked why she had to earn walks, the QMRP stated it was due to her behavior. When asked about consents for the plan, the QMRP stated there were no consents. The facility failed to ensure Individual #1's freedom of movement was not restricted without justification and approval of the HRC.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the parent/guardian for 2 of 5 individuals (Individuals #1 and 12) whose consents were reviewed. This resulted in a lack of protection of individual rights through prior approvals on restrictive interventions. The findings include: 1. Individual #12's PCP, dated 1/24/06, documented a 29 year old female diagnosed with schizoaffective disorder, obsessive compulsive disorder, mild mental retardation, history of boderline personality disorder, and insulin dependent diabetes mellitus. During an observation on 8/21/06 at 3:40 p.m., a	W 263		

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W 263	Continued From page 52 direct care staff was interviewed regarding the level of supervision required for individuals living in the Birch 2 unit. He stated Individual #12 was on enhanced supervision when she was in her bedroom or bathroom, due to inserting items in her rectum. At 4:05 p.m. Individual #12 asked the QMRP to take her to the restroom. When asked, on 8/23/06 at 9:20 a.m., if guardian approval for restricting Individuals #12's privacy had been obtained, the QMRP stated the facility did not consider 1:1 a restrictive intervention and a consent had not been obtained. 2. Individual #1's PCP, dated 6/20/06, documented an 18 year old female diagnosed with mild mental retardation, schizoaffective disorder bipolar type, oppositional defiance disorder by history, borderline personality disorder, gastroesophageal reflux disease (refers to the clinical manifestations of reflux of stomach contents into the esophagus), and gallstones. She was admitted to the facility on 5/22/06. A Physician's Order, dated 7/23/06, stated cultures were to be obtained from Individual #1's nose, oral pharynx, and any open wounds and "Restrict to unit - may go outside on unit. No swimming." A Physician's Order, dated 7/26/06 stated Individual #1's left forearm wound swab grew MRSA. Contact isolation was instituted and Individual #1 was restricted to her room. An Interdisciplinary Progress Note, date 7/31/06 and signed by the QMRP, stated "Criteria will be set up for her to earn walks outside with 2 staff preferably 3x/day. When she takes theses walks, [Individual #1] must wear long sleeved shirts,	W 263		

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W 263	Continued From page 53 mask to face (due to MRSA)." Individual #1's record contained a plan titled "Criterion For Going On A Walk." The plan was undated and stated "[Individual #1 will be able to earn 3 walks per day, one between 9am and 12pm, one between 12pm and 3pm and one between 3pm and 6pm. In order to earn her walk the following criterion must be met: 1) No behaviors such as scratching, picking, yelling at staff or manipulating staff for at least one hour prior to going out for the walk. 2) No statements about having behaviors for at least one hour prior to going for the walk ...If [Individual #1] has behaviors or there are issues during a walk then [Individual #1] will not be able to earn a walk during the next time period." When asked about the plan, the QMRP stated during an interview on 8/24/06 from 9:30 - 11:05 a.m., the plan was put in place on 7/27/06. When asked why she had to earn walks, the QMRP stated it was due to her behavior. When asked about consents for the plan, the QMRP stated there were no consents. The facility failed to ensure Individual #1's freedom of movement was not restricted without justification and consent from her guardian.	W 263		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure that techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This resulted in individuals not receiving behavioral services and interventions consistent with their needs. The findings include: 1. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments were current, comprehensive, and accurately identified an individual's behavioral status and needs. 2. Refer to W234 as it relates to the facility's failure to ensure individuals' behavior plans included sufficient direction to staff. 3. Refer to W262 as it relates the the facility's failure to ensure restrictive interventions were implemented only with the approval of the human rights committee. 4. Refer to W263 as it relates to the facility's failure to ensure restrictive interventions were implemented only with the written informed consent of the individuals' guardians. 5. Refer to W269 as it relates to the facility's failure to ensure staff actively engaged in	W 266		

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W 266	Continued From page 55 practices which provided individuals with opportunities for choice, decision-making and self-management and promoted participation in those opportunities. 6. Refer to W287 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were not used for the convenience of staff. 7. Refer to W288 as it relates to the facility's failure to ensure specific active treatment programs addressing inappropriate behavior and mechanisms to teach appropriate behavior were written into program plans. 8. Refer to W295 as it relates to the facility's failure to ensure the severity of an individual's behavior justified the use of physical restraints. 9. Refer to W312 as it relates to the facility's failure to ensure behavior modifying drugs were used only as a comprehensive part of an individual's PCP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed. 10. Refer to W313 as it relates to the facility's failure to ensure behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs.	W 266		

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W 269	483.450(a)(1)(ii) CONDUCT TOWARD CLIENT These policies and procedures must address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure staff actively engaged in practices which provided individuals with opportunities for choice, decision-making and self-management and promoted participation in those opportunities for 1 of 1 individual (Individual #1) observed to be isolated to her bedroom. This resulted in an individual having no voice in how her meals were prepared or where she ate. The findings include: 1. Individual #1's PCP, dated 6/20/06, documented an 18 year old female diagnosed with mild mental retardation, schizoaffective disorder bipolar type, oppositional defiance disorder by history, borderline personality disorder, gastroesophageal reflux disease (refers to the clinical manifestations of reflux of stomach contents into the esophagus), and gallstones. She was admitted to the facility on 5/22/06. During an observation on 8/22/06 from 12:55 - 2:43 p.m., Individual #1 was noted to be isolated to her room. When asked, present staff stated at 1:00 p.m., Individual #1 had MRSA and was on room restriction. Individual #1's record contained a Physician's Order, dated 7/23/06, which stated cultures were to be obtained from Individual #1's nose, oral	W 269		

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W 269	Continued From page 57 pharynx, and any open wounds and "Restrict to unit - may go outside on unit. No swimming." A Physician's Order, dated 7/26/06 stated Individual #1's left forearm wound swab grew MRSA. Contact isolation was instituted and Individual #1 was restricted to her room. The unit's communication logs documented breakfast food items, dishes, and eating utensils were modified without input from Individual #1 as follows: -7/25/06: An entry in the unit's communication log stated "[Individual #1] can use regular plates and silverware. Staff need to get her place serving and wash it right after she is done eating and run it through the sanitizer right away before others touch her place setting." An entry in the unit's communication log, undated, stated "[Individual #1] will receive all meals on trays sent from dietary. Direct care staff need to open tray and give her the plates/bowls/silverware. When [Individual #1] is done eating, please put disposable dishes into bag provided by dietary. Then place bag of disposables back into tray (direct care staff to do this). The tray then can be placed on dietary cart." An e-mail entry in the unit's communication log, dated 7/27/06, stated "We will be changing [Individual #1's] breakfasts starting tomorrow. She will get a sack breakfast of cold cereal, fruit, and milk every day and this will be sent with dinner. Swing shift staff need to place this in the storage refrigerator when it is delivered. Day shift will need to get the breakfast out from storage	W 269		

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W 269	Continued From page 58 when [Individual #1] is ready to eat. This will eliminate the tray at breakfast (since there was no cart to put it on) and the bag can be disposed of appropriately when [Individual #1] is done eating." When asked why Individual #1 could not eat in the dining area either before or after others were finished eating, the QMRP stated during an interview on 8/24/06 from 9:30 - 11:05 a.m., she was were told it was due to MRSA. When asked about the change to paper plates, plastic utensils, and breakfast food items, the QMRP stated she was told it was due to MRSA. The facility failed to ensure Individual #1 was provided with opportunities to make choices and decisions about where she ate her meals, the type of plates and utensils used, and the content of her breakfast meal.	W 269		
W 287	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on individual and staff interviews and a review of smoking guidelines, it was determined the facility failed to ensure techniques were not used to compensate for lack of staff presence/competency for 1 of 1 individual (Individual #15) interviewed who reported concerns with restrictive interventions. This resulted in the implementation of unauthorized	W 287		

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W 287	Continued From page 59 restrictive interventions. Findings include: 1. Individual #15 was a 35 year old male diagnosed with mild mental retardation, depressive disorder, sleep disorder, post traumatic stress disorder, delusional ideation, sexual disorder, and history of seasonal affective disorder. During the survey on 8/22/06 at 2:00 p.m., Individual #15 asked to speak with a surveyor. He told the surveyor his concern was that since the last survey, he could no longer go outside in the back of the facility (onto the patio/into the backyard) without a 1:1 staff with him. He said that staff was not routinely available to provide such supervision, and as result he was not getting out to water his flowers and to smoke at the frequency he desired. He showed the surveyor a protocol posted on the wall next to the patio door titled - "Aspen 2: Staffing need when clients outside smoking or other." The protocol read (in part): "Due to high safety concerns when they are outside both individuals (a peer & Individual #15) will require a staff each one of them for when they are outside. However due to our limited staffing we can not accommodate 1 staff for (peer) and 1 staff for (Individual #15), when they are outside. Therefore, because we only have 1 staff to accommodate these two individuals, it is not feasible that they be outside at the same time." Individual #15's QMRP was interviewed on 8/23/06 at 12:30 p.m. When asked if Individual #15 was required to have 1:1 staff in any other setting than what he described, she replied no. She said that the 1:1 supervision was only to be	W 287		

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W 287	Continued From page 60 provided when he was outside in back of the living facility. She stated that the procedure had been implemented on 6/28/06 because Individual #15 had been leaving staff's line of sight when on the patio (staff were to have been providing visual monitoring of Individual #15 from inside the living unit) and it was felt that his intent/plan was to sexually target a client on the other side of the building should he succeed in getting out of staff's visual range. It was unclear how Individual #15 would be able to do so if staff maintained line-of-sight supervision. The facility failed to ensure techniques used to manage inappropriate behavior were not used for the convenience of staff.	W 287		
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure techniques to manage the inappropriate behavior for 1 of 7 individuals (#12) whose behavior management programs reviewed, were not used as a substitute for an active treatment program. This resulted in restrictive interventions being utilized without a training program plan to teach the individual appropriate behavior, and without a corresponding specific objective related to use of the restrictive intervention. Findings	W 288		

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W 288	Continued From page 61 include: 1. Individual #12's PCP, dated 1/24/06, documented a 29 year old female diagnosed with schizoaffective disorder, obsessive compulsive disorder, mild mental retardation, history of borderline personality disorder, and insulin dependent diabetes mellitus. During an observation, on 8/21/06 at 3:40 p.m., a direct care staff was interviewed regarding the level of supervision required for individuals living in the Birch 2 unit. He stated Individual #12 was on enhanced supervision when she was in her bedroom or bathroom, due to inserting items in her rectum. At 4:05 p.m. Individual #12 ask the QMRP to take her to the restroom. Another direct care staff was interviewed, at that time, and he stated Individual #12 had been placed on heightened supervision due to the results of her colonoscopy. A review of her medical records included a nursing note, dated 6/7/06, stating a pencil was found in the garbage can with "frank blood also frank blood on toilet." The notes documented Individual #12 stated she had stuck the pencil up her colon due to being constipated. A nursing note, dated 6/24/06, stated "DCS called nurse and stated they had found broken hanger, towel and gloves in [Individual#12's] bathroom all had semi-dry stool on them." On 6/27/06 the nursing notes included a late entry for 6/25/06, which stated "BM on gloved finger neg. for bld (blood). Also ends of hangers did not have bld on or BM on them - BM spattered on hangers only." Her medical records included discharge	W 288		

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W 288	Continued From page 62 instructions from Boise Endoscopy, dated 8/11/06, to "STOP putting things in your bottom." The findings on the discharge instructions stated there was intense rectal inflammation. The Physician's Orders and Progress Notes, dated 8/11/06, stated "there is scar tissue inflammations in rectum and that damage is chronic and new." A second entry on 8/11/06 stated "Colonoscopy revealed extensive trauma to [Individual #12's] rectum with inflammatory changes - secondary to [Individual #12] inserting objects &/or finger into rectum." Individual #12's records included an "Initial Request for Enhanced Supervision", dated 6/24/06, which stated she had inserted items in her rectum due to being constipated. The form stated Individual #12 was to be at arms length supervision when she was eating (to monitor rate of intake and eating food not allowed due to her diabetes) or using the restroom. Individual #12's BSP, undated, did not address the behavior of rectal insertion. During interview, on 8/23/06 at 9:10 a.m., the QMRP stated Individual #12 did not have a program for rectal insertion. The facility failed to provide Individual #12 with specific active treatment programs addressing both the inappropriate behavior and mechanisms to teach appropriate behavior.	W 288		

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W 295	483.450(d)(1)(i) PHYSICAL RESTRAINTS The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the the severity of individuals' behavior justified the use of physical restraints for 1 of 7 individuals (Individual #13) whose behavior support plans were reviewed. This resulted in the potential for inappropriate interventions to be used. The findings include: 1. Individual #13's PCP, dated 1/18/06, documented a 24 year old male diagnosed with profound mental retardation, intermittent explosive disorder, seizure disorder, cerebral palsy with spastic quadriplegia, and scoliosis of the spine. He used a wheelchair for ambulation and mobility. Individual #13's BSP, titled Manage Mood, updated 8/1/06, stated "During 2005, [Individual #13] has engaged in more frequent low intensity self-injurious behaviors such as finger picking, scratching and pinching himself. [Individual #13's] finger picking occurs most frequently during the night while he is wearing his mitts. (He could still rub his fingers with his thumb inside the mitts). The goal manager, occupational therapist and adaptive equipment specialist reviewed the information and instructed staff to use a glove made of wicking material inside the mitt which seems to have been helpful. A sensory	W 295		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 295	Continued From page 64 assessment was performed and indicated that [Individual #13's] scratching and pinching behaviors may actually be attempts to calm himself by providing deep pressure input." The program stated Individual #13 had the ability to independently remove the mitts. Under the section titled Procedures When [Individual #13] Goes to Bed, it stated "Night shift staff will apply the mitts when [Individual #13] goes to sleep ...after another hour, Night Shift staff attempt to remove the mitts if [Individual #13] is not engaging in any challenging behaviors. Leave the mitts off unless [Individual #13] starts to engage in challenging behaviors, in that case, reapply the mitts for the remainder of the night. Under the section titled Interventions For Non-Targeted Behaviors, it stated if Individual #13 was picking at his fingers, staff were to apply lotion, rub the area using firm pressure, and offer him a sensory activity. If Individual #13 was scratching himself, staff were to apply lotion, rub the area using firm pressure, offer him a sensory activity, and inspect and trim his fingernails. If Individual #13 was pinching himself, staff were to rub the area he was pinching using firm pressure and offer him a sensory activity. When asked about data supporting the use of the mitts, the QMRP stated on 8/22/06 at 12:20 p.m., there was no data because Individual #13 did not have 1:1 staff to monitor him during the night. Individual #13's PCP did not include objectives related to finger picking, scratching, or pinching himself. The QMRP confirmed on 8/22/06 at 12:20 p.m., there were no objectives developed for finger picking, scratching, or pinching himself.	W 295		

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	13G001	A. BUILDING _____ B. WING _____	R 08/28/2006

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W 295	Continued From page 65 The facility failed to ensure the severity of Individual #13's finger picking, scratching, and pinching behavior justified the use of mitts.	W 295		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' PCPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 5 individuals (Individual #1) whose medication plans were reviewed. This resulted in an individual receiving behavior modifying drugs without comprehensive plans that addressed the symptoms associated with her diagnoses. The findings include: 1. Individual #1's PCP, dated 6/20/06, documented an 18 year old female diagnosed with mild mental retardation, schizoaffective disorder bipolar type, oppositional defiance disorder by history, borderline personality disorder, gastroesophageal reflux disease (refers to the clinical manifestations of reflux of stomach	W 312		

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W 312	Continued From page 66 contents into the esophagus), and gallstones. Individual #1 was admitted to the facility on 5/22/06 and her routine behavior modifying drugs included Naltrexone (adjunct for maintenance of opioid free state in detoxified persons) 50 mg a day for self-injurious behavior, Seroquel (an antipsychotic) 200 mg a day for mood swings and psychotic behavior, and Prozac (an antidepressant) 20 mg a day for depressive symptoms. Her Comprehensive Psychiatric Evaluation, dated 6/2/06, stated Naltrexone was increased to 100 mg a day. An OPFR Charting note, dated 6/15/06, showed Seroquel was increased to 400 mg a day. Individual #1's BSP, dated 6/23/06, and revised 7/25/06, documented symptoms of depression, bipolar disorder, and brief psychiatric symptoms were being tracked and rated. The ratings were averaged each month and were included in the criteria to increase or decrease her behavior modifying drugs. The symptoms of depression, bipolar disorder, and brief psychiatric symptoms were as follows: - The "Depression Observation Checklist" included the following depression symptoms: frowning/sad expression, irritable (easily annoyed or made angry), appetite changes (eats small amount or no meal), loss of interest/enjoyable things (no longer engaging in pleasurable tasks/items), SIB, motor retardation/lethargy (fatigue/tiredness/sleepy), sleep disturbance (sleeping during day/wakeful periods during night/less than 6 hours sleep at night early awakening), weight loss, withdrawal (not interested in social contact),	W 312		

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W 312	Continued From page 67 agitation/restlessness (unable or unwilling to sit quiet or still), confusion in choice making (attempts to make choice but unable to decide or changes mind after choice made), decreased production at tasks/work, anger/frustration (fights back at person or thing), and constipation. When asked if Individual #1 displayed all of the above noted symptoms, the Clinician stated during an interview on 8/24/06 from 9:30 - 11:05 a.m., yes. When asked if Individual #1 had any plans in place to teach her how to cope with the symptoms, she stated no. - The "Bipolar Disorder - Assessment Manic Symptoms" included the following symptoms: elevated mood, increased motor activity (energy), sexual interest, sleep, irritability, speech (rate and amount), language-thought disorder, content, disruptive-aggressive behavior, appearance, and insight. When asked if Individual #1 displayed all of the above noted symptoms, the Clinician stated during an interview on 8/24/06 from 9:30 - 11:05 a.m., yes. When asked if Individual #1 had any plans in place to teach her how to cope with the symptoms, she stated no. - The "Brief Psychiatric Rating Scale (BPRS)" included the following symptoms: somatic concern, anxiety, emotional withdrawal, conceptual disorganization, guilt feelings, tension, mannerisms and posturing, grandiosity, depressive mood, hostility, suspiciousness, hallucinatory behavior, motor retardation, uncooperativeness, unusual thought content, blunted affect, excitement, and disorientation.	W 312		

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W 312	Continued From page 68 When asked if Individual #1 displayed all of the above noted symptoms, the Clinician stated during an interview on 8/24/06 from 9:30 - 11:05 a.m., yes. When asked if Individual #1 had any plans in place to teach her how to cope with the symptoms, she stated no. Further, under the section titled Current Psychotropic Medication Interventions in Individual #1's BSP, it showed Haldol 10 mg (PO or IM), Benadryl 50 mg (PO or IM), and Ativan 2 mg (PO or IM) were used PRN as a chemical restraint. The purpose of the chemical restraint was not identified and there was no criteria that identified how the drug usage may change. The facility failed to ensure plans were sufficiently developed to teach Individual #1 how to cope with the symptoms she exhibited related to her diagnoses, the purpose of the PRN chemical restraint was identified, and criteria that identified how the PRN drug usage may change was developed.	W 312		
W 313	483.450(e)(3) DRUG USAGE Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure behavior modifying drugs were not used until the	W 313		

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W 313	Continued From page 69 severity of the behavior was shown to outweigh the associated risks of the drugs for 1 of 5 individuals (Individual #1) reviewed who received behavior modifying drugs. This resulted in an individual receiving behavior modifying medication without the necessary justification. The findings include. 1. Individual #1's PCP, dated 6/20/06, documented an 18 year old female diagnosed with mild mental retardation, schizoaffective disorder bipolar type, oppositional defiance disorder by history, borderline personality disorder, gastroesophageal reflux disease (refers to the clinical manifestations of reflux of stomach contents into the esophagus), and gallstones. She was admitted to the facility on 5/22/06. Individual #1's OPFR Charting notes, dated 6/3/06 - 8/11/06, documented the following chemical restraints were given when Individual #1 was either calm or when she was spitting: - 6/3/06: An OPFR Charting note stated "At 1350 [staff's name] RN/AOD spoke with [doctor] and obtained an order for Ativan secondary to escalating beh. (behavior). At 1410 Ativan was adm (administered)..." An OPFR Charting note dated 6/3/06 at 2:10 p.m., stated "[Individual #1] is down to nrsg (nursing) station is agreeable to Ativan 1 mg ordered by [doctor]. Given PO without difficulty." - 7/9/06 at 8:35 p.m.: Individual #1 "began to DOP the kitchen and day hall and PAS (an area on the unit). She was placed in a prone and could not calm after 20 minutes...RN/AOD rec'd (received) orders for Ativan 2 mg for [Individual #1]. She	W 313		

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W 313	Continued From page 70 cont (continued) to be in prone - agreed to sit up and take by mouth...remained sitting on floor." At 8:45 p.m., Individual #1 "started picking scab and attempting to poke a 'stickerweed' into her arm and when staff attempted to redirect she assaulted, spit yelling again. BSP followed and [Individual #1] proned." At 8:55 p.m., Individual #1 "isn't calming - cont (continued) to SIB - pick, bite - attempting assault on staff spitting yelling...notified [doctor]...and rec'd (received) order for Haldol 10 mg and Benadryl 50 mg - PO if refused admin (administer) IM. [Individual #1] was put in HIS sit and took meds PO." - 7/30/06 at 2:16 p.m.: An OPFR Charting note, dated 7/30/06, stated Individual #1 was placed in a prone restraint and continued to spit blood at staff. A surgical mask was placed over her mouth and the QMRP was consulted. "[QMRP] was agreeable to use chemical restraint and ok to give IM secondary to blood spitting." The OPFR Charting note documented Haldol 10 mg, Benadryl 50 mg, and Ativan 2 mg were administered IM at 2:55 p.m. - 8/4/06 at 7:10 p.m.: An OPFR Charting note stated Individual #1 threw what appeared to be blood/saliva on a staff resulting in a prone restraint from 7:15 - 7:35 p.m. The doctor was called for a chemical restraint and at 7:20 p.m., Haldol 10 mg, Benadryl 50 mg, and Ativan 2 mg were administered IM due to "blood spitting." - 8/11/06 at 9:15 p.m.: An OPFR Charting note stated Individual #1 stated "chewing of inside of mouth and oral bleeding." The doctor was called for a chemical restraint and at 9:20 p.m., Haldol 10 mg, Benadryl 50 mg, and Ativan 2 mg were	W 313		

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W 313	Continued From page 71 administered IM. A Physician's Order, dated 8/11/06, stated "HIS restraint chewing of mouth with bleeding...chemical restraint given." The following side effects of Haldol, Benadryl, and Ativan were obtained from the Internet site, www.pdrhealth.com., and are as follows: - Haldol: breathing problems, cataracts, constipation, drowsiness, dry mouth, insomnia, involuntary muscle contractions, skin reactions, tardive dyskinesia, tightening of the throat muscles, and weight loss. - Benadryl: drowsiness, excitability, and nervousness or dizziness. - Ativan: Dizziness, memory problems, sedation, transient amnesia, unsteadiness, and weakness. When asked why Individual #1 was receiving chemical restraints when she was either calm or when she was spitting, the QMRP and Clinician stated during an interview on 8/24/06 from 9:30 - 11:05 a.m., they were not aware of that. The facility failed to ensure the intensity/severity of Individual #1's behavior clearly outweighed the potential harmful effects of Haldol, Benadryl, and Ativan prior to their continued use.	W 313		

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MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W122, W127 and W128.	MM177		
MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W288 and W295.	MM191		
MM192	16.03.11.075.09 (d) Drugs Drugs such as tranquilizers must not be used as chemical restraints to limit or control resident behavior for convenience of staff. This Rule is not met as evidenced by: Refer to W313.	MM192		

Bureau of Facility Standards

TITLE (X6) DATE

L' 'RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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MM194	Continued From page 1	MM194		
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194		
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196		
MM206	16.03.11.075.12(d) Individual Preferences Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, and entertainment must be elicited and respected by the facility. This Rule is not met as evidenced by: Refer to W269.	MM206		
MM207	16.03.11.075.13 Freedom of Association Freedom of Association. Each resident admitted to the facility must be permitted to associate and communicate privately with persons of his choice, and to participate in activities of social, religious, and community groups at his discretion, unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W133.	MM207		

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MM207	Continued From page 2	MM207		
MM211	16.03.11.075.17 Right to Appropriate Treatment Right to Appropriate Treatment, Services, and Habilitation. Residents have a right to appropriate treatment, services, and habilitation. This Rule is not met as evidenced by: Refer to W287.	MM211		
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W266.	MM212		
MM513	16.03.11.200.01 Governing Body Each facility will be organized and administered under one authority which may be a proprietorship, partnership, association, corporation, or governmental unit. If administered by other than a single owner or partnership, the facility will have a governing board which assumes full legal responsibility for the overall conduct of the facility and for full compliance with these rules. This Rule is not met as evidenced by: Refer to W102 and W104.	MM513		
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and	MM724		

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MM724	Continued From page 3 program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W214.	MM724		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725		
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W312.	MM729		
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and	MM855		

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MM855	Continued From page 4 habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W234.	MM855		

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MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W122, W127 and W128.	MM177		
MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W288 and W295.	MM191		
MM192	16.03.11.075.09 (d) Drugs Drugs such as tranquilizers must not be used as chemical restraints to limit or control resident behavior for convenience of staff. This Rule is not met as evidenced by: Refer to W313.	MM192		

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TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM194	Continued From page 1	MM194		
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194		
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196		
MM206	16.03.11.075.12(d) Individual Preferences Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, and entertainment must be elicited and respected by the facility. This Rule is not met as evidenced by: Refer to W269.	MM206		
MM207	16.03.11.075.13 Freedom of Association Freedom of Association. Each resident admitted to the facility must be permitted to associate and communicate privately with persons of his choice, and to participate in activities of social, religious, and community groups at his discretion, unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W133.	MM207		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	R-C 08/28/2006

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MM207	Continued From page 2	MM207		
MM211	16.03.11.075.17 Right to Appropriate Treatment Right to Appropriate Treatment, Services, and Habilitation. Residents have a right to appropriate treatment, services, and habilitation. This Rule is not met as evidenced by: Refer to W287.	MM211		
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W266.	MM212		
MM513	16.03.11.200.01 Governing Body Each facility will be organized and administered under one authority which may be a proprietorship, partnership, association, corporation, or governmental unit. If administered by other than a single owner or partnership, the facility will have a governing board which assumes full legal responsibility for the overall conduct of the facility and for full compliance with these rules. This Rule is not met as evidenced by: Refer to W102 and W104.	MM513		
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and	MM724		

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MM724	Continued From page 3 program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W214.	MM724		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725		
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W312.	MM729		
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and	MM855		

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MM855	Continued From page 4 habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W234.	MM855		